Filed 2/23/10 Antelope Valley Healthcare Dist. v. Director of the Calif. Dept. of Health Services CA2/3

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION THREE

ANTELOPE VALLEY HEALTHCARE DISTRICT, Plaintiff and Appellant, v. DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, Defendant and Respondent, MOLINA HEALTH CARE OF CALIFORNIA, Real Party In Interest.	B207972 (Los Angeles County Super. Ct. No. BS110801)

APPEAL from a judgment of the Superior Court of Los Angeles County, David Yaffe, Judge. Reversed and remanded with directions.

Hooper, Lundy & Bookman, Craig J. Cannizzo and Felicia Y. Sze for Plaintiff and Appellant.

No appearance for Respondent.

Rogers Joseph O'Donnell, Neil H. O'Donnell and Thomas D. Blanford for Real Party In Interest.

I. INTRODUCTION

Antelope Valley Healthcare District (Antelope Valley) appeals from a judgment denying its petition for writ of administrative mandamus. Antelope Valley's petition sought to set aside an administrative decision by the Director of the California Department of Health Care Services (DHS). The DHS decision had denied Antelope Valley's appeal to be reimbursed at its cost-based interim rate for emergency services Antelope Valley provided to prepaid health plan enrollees of Molina Healthcare of California (Molina). We conclude that the DHS and the trial court erroneously determined that Antelope Valley would be reimbursed for emergency services pursuant to a provision in a Medi-Cal contract between DHS and Molina pursuant to section 53855, subdivision (e), of Title 22 of the California Code of Regulations.[1] Instead, this dispute is governed by a regulation (Cal. Code Regs., tit 22, § 53698) which determined that emergency services provided by Antelope should be compensated by the applicable interim rate. We reverse the judgment and remand the matter with directions to grant the mandamus petition.

II. FACTUAL AND PROCEDURAL BACKGROUND

A. The parties:

1. Antelope Valley Healthcare District

Appellant Antelope Valley is a public agency in Lancaster, California organized pursuant to the Local Health Care District Law (Health & Saf. Code, § 3200 et seq). Antelope Valley operates Antelope Valley Hospital, which has an emergency services department.

Antelope Valley treats Medi-Cal patients and has contracted with the State to be a Medi-Cal provider in the Selective Provider Contract Program (SPCP). SPCP contracts are negotiated by the California Medical Assistance Commission (CMAC), a California state agency (Welf. & Inst. Code, §§ 14082 and 14082.5). A hospital's status as an SPCP contractor is public knowledge, but reimbursement rates in the contract are not subject to

[1] Unless otherwise specified, the terms "section" or "sections" will refer to Title 22 of the California Code of Regulations.

disclosure under the Public Records Act (Govt. Code, § 6254, subd. (q).) Hospital-specific rates are not public, but the CMAC annually publishes the average of rates it has negotiated with SPCP hospitals (hereinafter "average CMAC rates"). (Welf, and Inst. Code, § 14165.9, subd. (d).)

The DHS reimburses Antelope Valley directly for inpatient services for Medi-Cal enrollees pursuant to the SPCP contract. Services that Antelope Valley provides to Medi-Cal members under its SPCP contract with the State, however, are not at issue in this case. The issue in this case involves how Molina reimburses Antelope Valley for emergency services it provides to Medi-Cal patients who are enrollees of Molina.

2. The Department of Health Services

The DHS is a State of California agency that administers the Medi-Cal program.

3. Health Net Health Plans and Molina

Health Net Health Plans (Health Net) is a managed care health plan that participates in California's Medi-Cal program, which impliments the federal Medicaid program. Health Net assigned certain of its obligations to Molina. Molina is a licensed health maintenance organization under subcontract with the DHS to provide health care service to Medi-Cal managed care beneficiaries in the Antelope Valley.

B. The Two-Plan Model

Medi-Cal has two approaches to healthcare delivery. In the traditional fee-for-service approach, the State pays providers such as Antelope Valley directly for care it provides to Medicaid patients. In the managed care approach, the State pays a health plan such as Health Net a capitated rate to provide a defined scope of services. California implements the managed care approach through numerous models, including the Two-Plan Model. Under that model, two health plans—one a local initiative (typically part of the county government) and the other a commercial plan—provide managed care coverage to Medi-Cal beneficiaries in a particular region, usually a county. The health plans provide this coverage through both contracted and non-contracted health care providers. This case concerns the Two-Plan Model in Los Angeles County in which Health Net/Molina is the commercial plan.

C. The Health Net contract with the DHS

In its contract with the DHS, Health Net agreed to cover necessary emergency medical services provided to its enrollees. The Health Net contract defines the reimbursement rate that Health Net will provide a hospital for emergency inpatient hospital services. That contract clause sets the rate to be paid if the hospital is a SPCP provider but has no contract with the health plan:

> "C. For hospital inpatient services, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan Emergency Services, to an non-contracting Emergency Services provider shall be the lower of the following rates applicable to the provider at the time the services were rendered by the provider:
>
> "[¶] . . . [¶]
>
> "2. For a provider contracting with the State under the Selected Provider Contracting Program, the lower of:
>
> "a. The average California Medical Assistance Commission (CMAC) rate for the geographic region . . . in which the provider is located . . . ; or
>
> "b. The inpatient rate negotiated by Contractor or sub-contractor with the provider."

D. Antelope Valley had no contract with Health Net

Antelope Valley treated Medi-Cal patients enrolled in the Health Net plan even though Antelope Valley did not have a contract with Health Net. That is because federal and state law required Antelope Valley to treat all patients for medical emergencies. Antelope Valley thus is a non-plan provider. Any managed care plan under the Two-Plan Model must pay for such "emergency medical services without prior authorization." (Cal. Code Regs, tit. 22, § 53855(a).) The issue in this case is the amount of reimbursement Health Net must pay to Antelope Valley for providing inpatient hospital services to Health Net enrollees.

E. The dispute concerning reimbursement of Antelope Valley for emergency health care services provided to enrollees of Health Net/Molina

In October, November, and December 2004, Antelope Valley provided emergency health care services to enrollees of Health Net/Molina. Antelope Valley billed Molina for those services. For this billing period, the DHS had not established a final rate for Antelope Valley for these emergency services. Molina paid Antelope Valley for those services at the "CMAC rate," the average CMAC rate for services within the geographic area, as published in the most recent CMAC annual report to the California Legislature. Antelope Valley believed this compensation was erroneous, and that it should be paid its cost-based interim rate for emergency services provided to enrollees of Molina.

On March 18, 2005, Antelope Valley submitted claims to DHS for emergency services that Antelope Valley rendered to Molina enrollees in October, November, and December 2004. The claims sought the difference between the CMAC rate and Antelope Valley's claimed interim rate of 35 percent of billed charges in accordance with Title 22 of the California Code of Regulations, section 53620 et seq. Health Net/Molina filed a Notice of Defense asserting that it already paid appropriate amounts for the services. The matter was heard before the DHS Administrative Law Judge on January 26, 2006. The DHS adopted the Administrative Law Judge's proposed decision as the final decision.

The decision stated that the matter required a determination as to which of two regulations governs the rate of reimbursement to be paid by two-plan model contractors (such as Health Net/Molina) to non-plan providers for inpatient emergency services. The decision dealt with two separate regulations. Section 53855, subdivision (e) states:

> "(e) For emergency inpatient hospital services, payment shall be made in accordance with the provisions of the contract between the plan and the department."

Section 53698 states:

> "(a) The plan's financial liability to the provider, if any, shall not exceed the lower of the following rates applicable at the time the services were rendered.

> "(1) The usual charges made to the general public by the provider;
>
> "(2) The fee-for-service rate for similar services under the Medi-Cal program. Upon determination of the plan's liability, if no final rate has been established for a provider for the period and type of services in question, then the applicable interim rate shall be used for final determination of plan liability."

Health Net/Molina claimed that section 53855, subdivision (e) was the substantive payment provision, requiring Molina to pay Antelope Valley for inpatient emergency services in accordance with the contract between Health Net/Molina and the DHS. Antelope Valley, by contrast, claimed that section 53698 set the rate of payment.

The DHS decision found that section 53855, subdivision (e) contained express, unambiguous language regarding payments to be made by a plan for emergency inpatient hospital services. Section 53698, subdivision (a)(2), however, set forth a reimbursement rate if a final rate was not established for the services in question, which suggested that section 53698 was also a payment provision which would result in a different rate of reimbursement than reimbursement under section 53855. The DHS decision stated that these apparently conflicting provisions had to be reconciled under rules of statutory construction. It concluded that section 53855, subdivision (e) applied. "Where, in the California Medical Assistance (Medi-Cal) Managed Care Program, a non-plan provider renders emergency inpatient services to plan beneficiaries, the non-plan provider will be reimbursed at the rate specified in the Two-Plan Model Managed Care contract." Thus the Health Net-DHS contract set the rate at which Molina would reimburse Antelope Valley for emergency services it provided to Molina enrollees.

On August 29, 2007, Antelope Valley filed a petition for writ of administrative mandamus which sought to set aside the DHS decision that denied its appeal, in which Antelope Valley had sought reimbursement at its cost-based interim rate for emergency services provided to prepaid health plan members of Molina.

In its March 10, 2008, order, the trial court denied the petition for writ of mandate and issued a statement of decision. The trial court defined the dispute as one concerning

the rate at which Molina was to reimburse Antelope Valley for emergency services it provided to Health Net enrollees. The trial court found that section 53698 did not apply because it was not part of Chapter 4.1 of Title 22 of the California Code of Regulations. Chapter 4.1 was added to Title 22 to permit a commercial prepaid health plan (like that offered by Health Net), and a local initiative prepaid plan (organized by a county government), to be approved by the DHS for a given region. Under Chapter 4.1, Antelope Valley has an agreement with the DHS to provide inpatient care to emergency patients, and therefore agreed to accept CMAC rates for providing such services. The trial court found that section 53855, subdivision (e) governed the amount Antelope Valley can charge for such services. Because Antelope Valley agreed to provide such services at CMAC rates to Medi-Cal patients not enrolled in Health Net, it was required to provide those services at the same rate for Medi-Cal patients who were enrolled in Health Net.

The trial court found that the DHS did not abuse its discretion in so holding, and that the DHS decision correctly interpreted applicable law and regulations. Judgment denying the petition for writ of mandate was entered on April 11, 2008.

Antelope Valley filed a timely notice of appeal.

ISSUES

Antelope Valley claims on appeal that section 53698 requires Molina to pay Antelope Valley at its interim rate for the claims in this case

1. *Standard of Review*

In an appeal from a judgment denying a petition for administrative mandamus, on appeal this court ordinarily reviews the record to determine whether substantial evidence supports the trial court's findings. (*Manriquez v. Gourley* (2003) 105 Cal.App.4th 1227, 1233.) But where the determinative question is one of statutory or regulatory interpretation, an issue of law, we exercise our independent judgment. (*Ibid*.; *Taxara v. Gutierrez* (2003) 114 Cal.App.4th 945, 950.) Because of the administrative agency's familiarity with statutes and regulations within its jurisdiction and its expertise in interpreting them, this court accords great weight and respect to the administrative

construction of governing statutes and regulations. (*Yamaha Corp. of America v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 7, 11-13.)

2. *Section 63698 Governs the Reimbursement of Antelope Valley by Health Net/Molina for Emergency Service Antelope Valley Provided to Molina Enrollees*

A plan,[2] such as Molina, which has a contract with DHS to provide Medi-Cal covered services in a designated region, is required to deliver emergency care to Medi-Cal members. (§§ 53851, subd. (b)(6), 53855, subd. (a).) Antelope Valley and Molina have a dispute about the rate of reimbursement for claims for emergency services which Antelope Valley, a nonplan provider, provided to plan members of Molina.

Molina argues that section 53855, subdivision (e), part of a regulation captioned "Care Under Emergency Circumstances," should govern the payment for emergency inpatient hospital services. Section 53855, subdivision (e) states:

> "(e) For emergency inpatient hospital services, payment shall be made in accordance with the provisions in the contract between the plan and the department."

Antelope Valley argues that another regulation applies. It relies on section 53698, captioned "Standard of Liability," whose subdivision (a) states:

> "(a) The plan's financial liability to the provider, if any, shall not exceed the lower of the following rates applicable at the time the services were rendered by the provider:
>
> "(1) The usual charges made to the general public by the provider.
>
> "(2) The fee-for-service rates for similar services under the Medi-Cal program. Upon determination of the plan's liability, if no final rate has been established for a provider for the period and type of services in question, then the applicable interim rate shall be used for final determination of plan liability."

---

[2] "Plan means a prepaid health plan that has entered into a contract with the department." (§ 53810, subd. (cc).)

Section 53698 and section 53855, subdivision (e) give different results. Thus the issue is whether section 53855, subdivision (e) or section 53698 should govern the determination of the rate by which Molina reimburses Antelope Valley for its provision of emergency inpatient hospital services.

a. *Section 53855, Subdivision (e) Exceeded the Regulatory Authority of the DHS Because It Lacks Statutory Authority*

Authority cited for section 53855 includes Welfare and Institutions Code sections 10725, 14105, 14124.5 and 14312. (Cal. Code Regs., tit. 22, § 53855, p. 538.2(d).) None of these statutes provides authority for setting the rate of payment owed to a nonplan provider of emergency inpatient hospital services according to provisions in a contract between the plan and the DHS. Although Welfare and Institutions Code section 14105, subdivision (a) authorizes the DHS Director to prescribe policies and regulations to include rates for payment for services not rendered under a contract pursuant to Chapter 8 (commencing with Welfare and Institutions Code section 14200, the Waxman-Duffy Prepaid Health Plan Act), it does not authorize payment of a nonplan provider according to a contract to which that nonplan provider is not a party. An administrative agency may not adopt a regulation that exceeds the scope of, or is inconsistent with, the enabling statute. (*Bisno v. Santa Monica Rent Control Bd*. (2005) 130 Cal.App.4th 816, 821; Gov. Code, §§ 11342.1, 11342.2.)

b. *The Incorporation of the Molina-DHS Contract as a Substantive Provision of Section 53855, Subdivision (e) Was Prohibited*

Section 53855, subdivision (e) is a regulation that incorporates a private contract. It establishes the payment Molina makes to Antelope Valley according to provisions in the contract between Health Net and the DHS. Antelope Valley is not a party to that contract. In this respect section 53855, subdivision (e) incorporates an "underground regulation," a rule which only the government knows about. (*Kings Rehabilitation Center, Inc. v. Premo* (1999) 69 Cal.App.4th 215, 217.) Although section 53855, subdivision (e) may have complied with procedures for formalizing regulations in the Administrative Procedures Act (Gov. Code, § 11340 et seq. (APA)), the contract between

Molina and DHS did not. Yet the regulation uses the Molina-DHS contract to establish the rate of reimbursement of Antelope Valley, which was not a party to that contract. The Molina-DHS contract was not adopted in compliance with APA procedures for formalizing regulations, which include public notice and approval by the Office of Administrative Law; failure to comply with the APA nullifies the rule. (*Ibid*.; Gov. Code, § 11340.5, subd. (a).) The adoption of the Molina-DHS contract, or of all contracts between the DHS and a Medi-Cal plan, as a substantive part of section 53855, subdivision (e) also did not follow requirements for incorporation by reference in Title 1, section 20, subdivisions (c) and (e) of the California Code of Regulations.

An example of the problem of allowing regulation outside of the APA occurred when Health Net and the DHS amended their contract on October 1, 1998. The amendment stated that for a provider contracting with the State under the Selected Provider Contracting Program, reimbursement by a Contractor for inpatient services to an out-of-plan Emergency Services provider shall be "the lower of:

"a) The average California Medical Assistance Commission (CMAC) rate for the geographic region referred to as Standard Consolidated Statistical Area in which the provider is located for the last year reported, as published in the most recent CMAC Annual Report to the Legislature; or

"b) The inpatient rate negotiated by Contractor or subcontractor with the provider."

Section 53855 became effective on July 1, 1996. This contract amendment occurred later, on October 1, 1998, and also amended section 53855, subdivision (e), as applied to Antelope Valley. Under Molina's theory, Molina and the DHS could amend section 53855, subdivision (e) by amending their contract. It provides an example of an amendment to regulation which did not comply with the APA, did not follow requirements for incorporation by reference in Title 1, section 20, subdivisions (c) and (e) of the California Code of Regulations, and which incorporates a prohibited "underground regulation" known only the parties to the contract yet which applies to Antelope Valley, which was not a party to the Health Net-DHS contract.

c. *Antelope Valley Cannot Be Bound by a Contract to Which It Is Not a Party*

Moreover, Antelope Valley cannot be bound by a contract to which it is not a party. (*Retail Clerks Union v. L. Bloom Sons Co*. (1959) 173 Cal.App.2d 701, 703; see also *Clemens v. American Warranty Corp*. (1987) 193 Cal.App.3d 444, 452.) Thus the contract between Molina and DHS cannot set the compensation for emergency services performed by Antelope Valley, which was not a party to that contract.

d. *Section 53698 Is Part of Article 7, Which Addresses Emergency Services Claims Disputes, and Section 53855, Subdivision (f) Refers Such Disputes to Section 53698*

Welfare and Institutions Code section 14454, subdivision (a) specifically authorizes the plan's liability for all emergency services rendered by a nonprepaid health plan provider. It also authorizes the submission of a dispute concerning this liability to the DHS director, who shall by regulation provide for resolution of such dispute. Section 53620 is the regulation established for resolution of emergency services claims pursuant to Welfare and section 14454, subdivision (a).

Section 53620, subdivision (a) states: "The provisions of this article shall establish the procedures for Department resolution of disputes[3] concerning payment for emergency services rendered by non-plan providers[4] to prepaid health plan members who are Medi-Cal beneficiaries."

Thus Article 7, "Emergency Services Claims Disputes," specifically governs the dispute between Antelope Valley and Molina. The regulation relied on by Molina likewise refers disputes to Article 7; section 53855, subdivision (f) states: "If disputes arise over claims submitted by providers seeking reimbursement for the provision of emergency services to plan members, the parties shall adhere to the procedures and requirements prescribed in section 53875 for the resolution of such disputes." Section

---

[3] " 'Dispute' means a dispute concerning payment for care under emergency circumstances provided to plan members by nonplan providers." (§ 53622, subd. (a)(2).)

[4] " 'Provider' means a nonplan provider who files a claim against a plan for emergency services in accordance with this article." (§ 53622, subd. (a)(5).)

53875, in turn, states: "In resolving disputes over claims for reimbursement for emergency services provided to plan members by nonplan providers, the involved parties and the department shall adhere to the procedures and requirements set forth in Article 7 of Chapter 4, commencing with section 53620 except subsection (e) of section 53676."

Section 53698 is found in article 7 of chapter 4, which as we have stated, specifically governs "emergency services claims disputes." Because a dispute existed over claims submitted by Antelope Valley seeking reimbursement for the provision of emergency services to Molina members, section 53875 required the parties and the DHS to adhere to procedures and requirements in Article 7 of Chapter 4, in which section 53698, subdivision (a) established the liability of the plan (Molina) to the provider (Antelope Valley).

There was no final rate established for Antelope Valley for the period and for emergency inpatient hospital services. Therefore pursuant to section 53698, subdivision (a)(2) required the DHS to use the applicable interim rate[5] for final determination of Molina's liability to Antelope Valley.

---

[5] Section 53622, the "definitions" regulation of Article 7, contains no definition of "interim rate." Section 51545, the "definitions" regulation of Article 7.5, does contain a definition of interim rate, although subdivision (a) cautions that "[t]he following definitions are applicable to Article 7.5 only unless otherwise specified in another section[.]" Section 51545, subdivision (a)(45) states: "Interim Payment Rate means the rate paid to a provider, expressed as a percentage, derived by the PIRL divided by provider's charges." Section 51545, subdivision (a)(70) states: "Peer Grouping Inpatient Reimbursement Limitation (PIRL) means the lowest of the following:

"(A) Customary charges.

"(B) Allowable costs determined by the Department, in accordance with applicable Medicare standards and principles of cost based reimbursement, as specified in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1.

"(C) ARPDL.

"(D) PGRPDL.

"If a provider is exempt from peer group limits, the Medi-Cal reimbursement limitation will be the lowest of (A), (B) or (C), identified above. All references to PIRL include MIRL."

Section 53622, subdivisions (5), (71), and (54), respectively, define ARPDL, PGRPDL, and MIRL.

DISPOSITION

The judgment is reversed and the matter is remanded with directions to the trial court to vacate and set aside its judgment filed on April 11, 2008, and to enter a new and different judgment granting the petition for writ of administrative mandamus. Costs on appeal are awarded to plaintiff Antelope Valley Healthcare District.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

KITCHING, J.

We concur:

CROSKEY, Acting P. J.

ALDRICH, J.